# A Phased Approach to Achieving Universal Health Coverage in Colorado

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a) *Comprehensiveness*

(1) *What problem does this proposal address?* The uninsured and underinsured in Colorado. The lack of necessary systems to a) assure continuous coverage by all eligible persons, b) assure choice of health coverage and physicians, and c) improve the effectiveness, efficiency and safety of Colorado's health care system.

(2) *What are the objectives of your proposal?* As rapidly as funds are available and systems are built, to provide all Coloradans with at least basic health care coverage through a system of public-private partnership.

b) *General*

(1) *Please describe your proposal in detail.*

Kaiser Permanente Colorado proposes health coverage for all Coloradans in a series of steps:

1) Streamline and expand public programs.
2) Create the policy and administrative infrastructures needed to develop an effective and efficient health care system that: a) assures continuous coverage of qualified persons, and b) assures choice of health coverage options.
3) Expand coverage for all children age 18 and under, not eligible for public programs, including assistance for the lower-income.
4) Expand coverage for additional populations as funds permit.
5) Provide more comprehensive benefit plans as funds permit.

**Streamline and Expand Public Programs**: Using state flexibility through the Deficit Reduction Act, the HIFA waiver process, or other means, create a seamless process of eligibility that eliminates the administrative costs of children moving back and forth between CHP+ and Medicaid, adds cost-sharing to promote individual responsibility and

uses Health Maintenance Organizations (HMOs) to improve quality, access and cost management (resulting in savings to be used in subsequent steps). Through effective outreach, identify and add additional eligible children. Consider covering children at higher income levels.

Eligibility: All children eligible for Medicaid, CHP+ or the combined program will have 12 months of eligibility. Children who are eligible for a group plan will be required to accept that plan, with premium assistance for the lower income. This would have significant impact since about 30% of CHP+ children have prior employer-sponsored insurance (ESI). Nationally, about half those refusing ESI and enrolling in SCHIP said that ESI was unaffordable. However, premium assistance might alter that result. In addition, some might keep ESI if CHP+ would be a secondary payor for services not covered in the group plan. Therefore, we propose that the group plan will be primary. CHP+ will be the secondary payor in order to expand benefits to federal minimums (if necessary) and meet federal cost-sharing requirements. While this proposal will generate the most savings, additional state funds will be required. It will be essential to support coverage in the private sector for long-term sustainability of expanded coverage. Substituting public coverage for private coverage, "crowd-out," increases the cost to the public but does not decrease the number uninsured. There are alternative approaches to the one proposed in this section, and there are now HIFA waivers in other states supporting groups providing health coverage. These should be explored to meet the goal of maintaining or increasing private coverage more efficiently. At this phase, enrollment is still voluntary.

Outreach and enrollment: The state will need to systematically identify and enroll eligible children. An easy electronic eligibility and application process, available at multiple points, including hospitals and key outpatient providers, will be helpful. This type of system would also make the application process simpler and support the goal of streamlining public programs.

Benefits: Current Medicaid and CHP+ benefits need to be reassessed in light of the flexibility of the Deficit Reduction Act. The Deficit Reduction Act allows cost-sharing (both premiums and co-payments). All plans must have some level of cost-sharing in order to promote individual responsibility. HMOs will use their existing formularies. The benefit package should be re-evaluated once the Benefit Design Advisory Committee has completed its work. In addition, benefits should be assessed to ensure there are incentives and no barriers to use effective prevention services and evidence-based disease management services and that there are disincentives to overuse care or to use ineffective care. There is an important trade-off to consider: given a finite amount of public funds, should those funds be used to provide comprehensive benefits to a limited number of children, or should they be used for less comprehensive benefits for a larger number of people? This is work that the evaluation firm should model.

Providers: All HMOs volunteering to participate; all licensed physicians and other providers volunteering to participate; Federally Qualified Health Centers (FQHCs). In order to support quality and service, HMOs directly providing health care would be allowed to cap enrollment, as would individual physicians, physician groups and FQHCs. Because the entire state is not covered by HMOs, a statewide managed indemnity plan is required. This work should be bid out and should include a requirement that individuals in the managed indemnity program select a primary care physician (PCP) in order to have a medical home. The statewide managed indemnity plan also will provide disease management for those enrolling in the indemnity plan. PCPs will receive additional reimbursement for a defined set of services, based on the performance of the population of patients they serve, to assure the coordination of care and the promotion of health. Other providers such as local public health departments, school-based health centers, and the like should be considered for reimbursement through the statewide indemnity plan.

The goal is to have a high percentage of persons covered by HMOs who have a comprehensive focus on people to prevent illness, manage chronic illness, provide public information about quality and access, and improve efficiency. In order to have HMOs participate, the state must provide adequate reimbursement and reasonable administrative requirements. It will be important that a number of HMOs participate in Medicaid,

CHP+, or a combined program in order to build a base for coverage expansion to additional populations. We propose limiting this to HMOs as they are reimbursed on a capitated basis, making state expenses more predictable and giving them an incentive to manage overall care.

A medical home is essential to assure a child-centric approach to providing effective preventive services and effective and efficient health care. A recently published article in *Pediatrics* (December 2005) illustrated the power of a medical home using Colorado data (attached).

Employers: Developing a mechanism to assure that persons eligible for private health coverage remain in the private sector is essential for long-run sustainability of public programs. Without this component, the public would assume costs previously covered by the private sector, but the number of uninsured would not decrease. Substantial work has been done on how an employer-sponsored insurance (ESI) component might be incorporated into expansion of coverage using "premium assistance." This work will need to be reviewed, piloted, and modified as appropriate before public assistance is made available to additional populations.

Choice: Individuals/parents/guardians may choose their (or their children's) HMO or statewide managed indemnity plan. If they do not, they will be assigned. Within their HMO, they may choose their primary care physician (PCP), and must follow the HMO's procedures for changing PCPs. If they are in the managed indemnity plan, they may choose their PCP. If they do not, they will be assigned.

Reimbursement: In order to improve access and quality, and increase the number of physicians willing to provide care and willing to be a "medical home," it is essential that the state increase reimbursement rates. Fee-for-service providers through the statewide managed indemnity plan will be reimbursed at 100% of Medicare. HMOs will reimburse non-contract providers at 100% of Medicare. HMOs' rates will be set by an independent, qualified actuary using mainstream methodology, which then will be used to develop the program budget through an open process, well in advance of each successive state fiscal

year. The intent is that the rates will be actuarially sound and that sufficient funds allocated to implement these actuarially sound rates. Without these results, HMOs will not participate (nor should they), jeopardizing long-term results in quality and cost effectiveness.

Individual incentives: HMOs and the statewide managed indemnity plan will be encouraged to develop incentives for individuals to improve their health and their children's health. This might include, for example, completing a Health Risk Assessment (HRA) and personal health plan with their physician. In addition, it could include an incentive for being up to date on all recommended health screenings, for not using tobacco, and for having normal weight. The completion of a HRA and personal plan might have a small cash reward; for example, the completion of the personal plan might have credits for other health services such as co-payments, dental care, etc. Or plans could experiment with an incentive to reduce premiums. The overall structure of incentives must allow room for experimentation to discover what works best.

Reporting: All HMOs and the statewide managed indemnity plan will be required to report outcome, access/utilization and patient satisfaction data for this population on a yearly basis. These data must have standardized specifications and be audited. The state should consider requiring the use of standardized reporting systems such as Health Plan Employer Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The state should consider reporting requirements for FQHCs and other similar providers. Public reporting has been shown to stimulate improvements even with no financial or other reward attached.

Provider incentives: All HMOs, including the statewide managed indemnity plan, should have an incentive to perform well on quality, access/utilization, and patient satisfaction. These incentives could be additional reimbursement, additional default-assigned members, or a combination. Public reporting itself provides an incentive to improve performance. This public reporting also may affect enrollment by persons not covered by

CHP+ because other purchasers likely would use these published results in their own purchasing decisions.

Medicaid reform: Even if all children move to CHP+, there will continue to be a Medicaid program for the elderly and disabled. Medicaid will need to consider how to streamline its work and improve outcomes and efficiency for these persons, including a review of pharmaceutical management. The flexibility of the Deficit Reduction Act should be used to improve performance of the program, including adding cost-sharing.

**Build Necessary Systems**: To achieve universal coverage and support improving quality and efficiency, three systems are needed. One system will be built for enrollment, billing and collection to achieve continuous coverage of all qualifying persons. The second will be a system to assure all covered persons have access to health coverage. The third system will focus on the delivery of health care in order to efficiently provide reliable quality care and service. The work on these three areas can begin immediately, can be led by different groups and can proceed simultaneously.

## Assure Continuous Coverage of Qualifying Persons

In order to extend coverage beyond public programs, an effective and efficient system that assures all qualifying persons are continuously covered is required. Continuous coverage is essential to maintain/improve health, manage costs and assure choice of carrier (HMO, PPO or indemnity). Absent continuous enrollment, the incentive would be to get coverage only when a person needs care, greatly increasing average costs, reducing opportunities to prevent illness, and reducing carrier choice. This means that all qualifying persons must be required to be enrolled in a public program (CHP+, Medicaid or Medicare), be covered by an employer or other group, or directly purchase coverage from a carrier. Such a requirement, an individual mandate, places financial responsibility on the individual to either pay their share of a group premium, if any, or to pay for individual coverage. To make this a reasonable requirement on individuals,

reasonable cost plans must be available and financial assistance must be offered to lower-income individuals.

There are a number of administrative tasks necessary to assure continuous coverage.

Enrollment: At start up, and continually thereafter, all eligible persons must be identified and notified of their responsibility to have individual coverage. The state income tax system is the logical, most efficient method to manage this process. In addition, the system must allow eligible persons, who are residents of Colorado but who have not yet filed a state income tax return, to apply for premium assistance.

Premium assistance: Based on income, individuals must be assigned to one of several assistance levels. The greater the assistance, the less negative financial impact to individuals, but the larger the public support required. Again, there is a tradeoff: the more comprehensive the benefits, the higher the premium and the greater the public support. A public subsidy of 50% would have very different reactions if the premium were $100 rather than $200, for example. The Health Coverage Tax Credit has had low participation at 65% subsidy. The evaluation firm will need to model different assistance levels, but here is an example:

| **Percent of Federal Poverty Level** | **Subsidy per month based on the median cost basic plan or comprehensive plan with deductible available in the person's area** |
|---|---|
| <150% | 95% |
| 150%-200% | 85% |
| 201%-250% | 65% |
| 251%-275% | 50% |
| 276%-300% | 25% |
| Over 300% | No subsidy |

Verification of enrollment: Annually, all persons covered by the individual mandate must show proof of continuous enrollment in a qualifying plan (carriers would be required to issue this certificate annually). This would most easily be done as part of annual state income tax filing. For those not otherwise required to file state income tax, but who request premium assistance, an annual report of health coverage should be filed. As is currently required by HIPAA, employers (who may delegate this to a carrier) and insurers are required to issue to a member upon termination a "Health Insurance Certificate of Creditable Coverage." A copy of this certificate also should be provided to the state agency responsible for assuring universal, continuous coverage. The state agency would require the individual who terminated coverage to show evidence of new coverage.

Persons failing to enroll: A system to continue to collect the non-compliant individual's premiums will be essential. For working individuals who do not have group coverage, this could be a payroll deduction. For non-working individuals, another system would have to be devised. For individuals covered through a group plan, the group is responsible for collecting the individual/family portion of the premium, if any. In cases where the individual chooses to directly purchase a carrier's plan and does not pay their premiums, carriers must notify both the individual and the state agency. Carriers may request the state agency institute payroll deductions and pay the carrier, or otherwise arrange for the carrier to be paid, or the carrier may terminate the individual.

Collection of Cost-sharing: The collection of co-payment/co-insurance/deductibles is the responsibility of the provider or carrier (depending on organizational structure and contract arrangements). In order to have a sustainable system, it will be important to minimize bad debt. Individuals with unpaid bills should be referred to the state agency for financial counseling, the development of a financial plan to pay, review of any extraordinary financial events, and possible financial assistance.

Lack of enrollment: When a person fails to obtain health coverage, or when there is a lapse in coverage, a special tax must be charged to eliminate the incentive to only get coverage when care is needed.

Collection of premiums: The Colorado Department of Revenue also would collect an individual's share of premium and transfer those funds to the selected carrier. This system has been modeled through the Health Coverage Tax Credit work. While it should be a low-cost process, there have been surprisingly high administrative costs reported. This may be due to the newness of the program, complicated application procedures or low enrollment.

Group coverage: It will be essential to maintain at least the current financial level of employer-sponsored health coverage. Without at least maintenance of effort, public costs will increase. Therefore, individuals who are required to obtain coverage and are eligible for a group plan must select that plan. A system must be built to help lower-income persons pay for their share of the group premium. Premium assistance will be available to them only through their group plan. Consideration should be given to those employers who would prefer to get out of the health coverage business. Perhaps a system where the employer pays an equivalent amount of their historical health coverage expenditure to the state would suffice. Employers need to be consulted about this potential.

## Assure Choice of Health Coverage Options

Requiring everyone to be covered by health coverage also means that everyone must have options for that coverage. Requiring carriers to cover them (guaranteed issue) is a logical step. However, guaranteed issue has had severe unintended consequences in other states, including large premium increases and insurers leaving the market altogether. It is critical that careful attention be paid to minimizing those risks and assuring that coverage is available at reasonable rates.

Mandating coverage for all individuals (which can be phased in by age group) is an absolute requirement for successful implementation of guaranteed issue, but it alone is not sufficient for a good outcome. Steps must be taken to assure that people currently served in the individual market are not harmed and that the individual market remains viable.

The objective of the individual mandate plus guaranteed issue is to establish a functional, sustainable market where Coloradans who are not eligible for group coverage and are mandated to purchase health coverage through the individual market (with or without premium assistance) have guaranteed access to affordable coverage, regardless of health status.

Eligibility: All persons covered under the provisions of individual mandate must be covered either by CHP+, Medicaid, Medicare, a group plan or an individually purchased plan.

Benefits: While we believe comprehensive benefits are preferable, they probably would be prohibitively expensive to lower-income individuals, even with premium assistance. The 2006 premiums for Colorado's basic small-group plan in the Denver area had a median cost of approximately $300 per month for an employee aged 36. As an example, using $300 as the monthly price upon which premium assistance would be calculated, the monthly cost for an individual, aged 36, with income 251% - 275% of federal poverty level, with premium assistance, would be $150 per month. This probably is unrealistically expensive. The two potential adjustments would be to have less comprehensive benefits, lowering the price for which the premium assistance would be applied or increasing the subsidy. In order to extend premium assistance to all lower-income eligible Coloradans, we propose less comprehensive benefit packages initially.

We recommend modeling the following: For persons who do not qualify for a public program or group coverage, the following plans would be available on a guaranteed issue basis:

- A basic benefit plan with a $2,000 limit that would cover outpatient care, emergency care and pharmaceuticals. This would be the least expensive option and would cover all basic costs for a high percentage of people. Covering primary care would promote the goal of delivering effective preventive services and addressing health issues and health risks early.

- A plan with a deductible that follows the basic benefit level. After the deductible is met, all services would be covered. The deductible is included to make the plan more affordable for both the individual and the state. At least three deductible options should be modeled: $10,000, $2,000, and zero. After the deductible is met, comprehensive coverage with appropriate cost-sharing would be covered.

Premium Assistance: Premium assistance will be offered to persons who qualify based on family income and will be based on a percentage of the median cost plan (either the basic benefit plan or the comprehensive plan with deductible) in their service area.

Guaranteed Issue: As of a specified date, all licensed carriers who choose to participate in the individual market will be mandated to issue either a basic benefit plan, or the comprehensive plan with deductible to any qualified individual who is mandated to obtain coverage.

However, no carrier is required to offer coverage or accept applications pursuant to individual guaranteed issue if the insurance commissioner finds that acceptance of an application would place the carrier in a financially impaired condition. In addition, a carrier that has not offered coverage or accepted applications pursuant to this provision shall not offer coverage or accept applications until a determination by the commission that the carrier is no longer financially impaired. Carriers directly providing health care services, such as group model HMOs, may cease individual enrollment under guaranteed issue if they have insufficient provider capacity to continue to guarantee issue and meet the care requirements of existing contracts (group, individual, CHP+, Medicaid, Medicare). In that case, the carrier must develop a plan to increase capacity in order to resume individual guaranteed issue in the future.

A carrier shall issue a basic benefit plan or a comprehensive plan with deductible to any eligible individual that applies for such health benefit plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan.

Family members may enroll in separate benefit plans, but are deemed to be enrolling in separate contracts. Family rating, family deductible limits and family out-of-pocket maximums apply only within a contract.

Open enrollment: Upon initial implementation of the individual mandate and guaranteed issue, individuals may apply to any carrier in that service area for any individual guaranteed issue product offered by that carrier. The insurance commissioner may propose a limit on the number of individuals who receive guaranteed issue coverage from any single carrier, based on a plan's fair share.

After the initial implementation, individuals may change plans/carriers as follows:

- Annually, in the month of the individual's birthday, the individual may change carriers and/or may move from the basic benefit plan to a comprehensive plan with deductible or vice versa. If more than one deductible plan is offered, the individual may move to a higher deductible plan, but may move only one level to a lower deductible plan. For example, if there are three deductible plans: $10,000, $2,000 and zero, a person with a $10,000-deductible plan may move to the $2,000-deductible plan but not to the zero-deductible plan. This restriction is necessary to encourage individuals to plan longer term and to reduce adverse selection.
- At significant life events (e.g., exhaustion of state or federal continuation coverage, loss of group benefits, marriage, death of a spouse, death of a dependent, divorce), the individual may move from a basic benefit plan to any comprehensive plan with deductible or vice versa.

Guaranteed issue and open-enrollment rules do not apply to individuals who cannot demonstrate 12 months of continuous coverage (not applicable at start up). Carriers will refer those individuals to the state agency for resolution.

The time limitation on enrollment protects the more comprehensive plans from accruing a high level of risk that would result in making them unaffordable. It also encourages people to choose benefit plans that will meet their needs over the long term.

At the time individual mandate becomes effective for any population group, persons in that population group with an existing individual plan may remain in that

individual plan according to existing state law and regulations. However, subject to open enrollment rules, existing members may switch into a guaranteed issue product. Upon that election, they may not switch back to the non-guaranteed issue plan. Carriers are not required to maintain existing plans, and may offer renewing members only the guaranteed issue plans.

Individuals switching carriers, in accord with open-enrollment rules, may apply any covered expenses which accrued toward a calendar-year deductible or an out-of-pocket limit to the new carrier's calendar-year deductible, up to the limit of the new deductible. Expenses are defined by the initial carrier's definition of covered expense. Other than network requirements, the expenses must be for a service or supply which is covered under the new plan.

Provider networks: Carriers shall continue to have flexibility in establishing and maintaining provider networks as long as the carrier meets reasonable access to care.

Rating rules: The premium rate charged during a rating period to individuals shall be based on a single, same-index rate, applicable to all individuals, adjusted for case characteristics and coverage. The carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period. The carrier shall not use case characteristics other than age, geographic area, and family composition. The insurance commissioner may establish rules to implement these provisions and to assure that rating practices used by carriers are consistent with the purposes of this section, including rules that assure that differences in rates charged for health benefit plans by carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the individuals assumed to select particular health benefit plans.

Individual responsibilities: Individuals elect a guaranteed issue plan and carrier. Individuals complete a standardized health risk appraisal and health status questionnaire to assist plans in identifying persons with risk factors, in need of disease management and who are at high risk. Prior identification of persons in need of services to reduce their risk

(e.g., tobacco cessation) or manage their disease allows plans to reach out to these people to encourage them to get the care they need. Prior identification of high risk applicants will facilitate the re-insurance/risk adjustment mechanism discussed below. The identification of "high risk" applicants would be invisible to the enrollee, except to the extent they are candidates for disease management or services to reduce their risks.

Persons not maintaining continuous qualifying coverage: Carriers must add a surcharge, determined by the state agency, for each month of non-coverage (including breaks in coverage), to be measured from the last date of 12 months of continuous coverage. If the individual changes carriers, the new carrier must also add the surcharge. Applicants must include a copy of the "Health Insurance Certificate of Credible Coverage" when applying for coverage with a new carrier. Surcharges are in addition to tax penalties for non-compliance.

Individual incentives: Carriers will be encouraged to develop incentives for individuals to improve their health (and their children's health). This might include, for example, completing a Health Risk Assessment (HRA) and personal health plan with their physician. In addition, it could include an incentive for being up-to-date on all recommended health screenings, for not using tobacco, and for having normal weight. The completion of a HRA and personal plan might have a small cash reward, for example the completion of the personal plan might have credits for other health services such as co-payments, dental care, etc. In addition, plans could experiment with an incentive to reduce premiums. Carriers must have the flexibility to experiment to discover what works best.

Proof of coverage: Annually, each carrier must provide all covered enrollees proof of coverage for covered months during that year. Upon termination by an individual, carriers must provide a certificate of coverage for the relevant months as they currently do under HIPAA.

Report cards: All carriers will be required to report outcome, access/utilization and patient satisfaction data for this population on a yearly basis. These data must have standardized specifications and be audited. The state should consider requiring the use of standardized reporting systems such as HEDIS® and CAHPS®. The state should consider reporting requirements for FQHCs and other similar providers.

Provider incentives: Carriers will compete on the basis of price, quality and service, not risk selection. All carriers, including the statewide managed indemnity plan, should have an incentive to perform well on quality, access/utilization and patient satisfaction. These incentives could be additional reimbursement, additional default-assigned members, or a combination. Public reporting itself provides an incentive to improve performance and may affect total enrollment.

The state would act as the "referee," establishing the rules and preventing carriers from designing plans to avoid high-risk enrollees.

Risk assessment and risk adjustment: Risk assessment and risk adjustment provide a means of measuring and removing the effect of the relative "healthiness" or "unhealthiness" of persons choosing a health plan from the price. Applying appropriate risk assessment and risk-adjustment methods will result in consumer prices that are primarily based on differences in efficiency, quality and other attributes of carriers, but not on the relative "health" of the persons enrolled in the plans. This is essential to assure that carriers do not compete on the basis of avoiding risk. In addition, the mechanism must reinforce the carriers' obligation to effectively manage care.

Standardization of benefits is one necessary approach to addressing selection bias, as are individual mandates, guaranteed availability, renewability and continuity of coverage, and uniform pricing methods. Even with these features, which already are recommended in this proposal, differences in the risks of enrolled persons in different plans may remain.

Applying the tools of risk assessment and risk adjustment can reduce the impact of these differences and lead to market-based plan prices that primarily reflect plans'

efficiencies. This is essential to developing an effective and efficient health care system in Colorado.

There is a large body of work about techniques that assess risks. The state agency should seek experts in this field and contract for an ongoing risk assessment/adjustment system that accurately predicts the risk of groups of individuals, contains no systematic biases, can be easily and cost-effectively applied, and is immune to gaming/manipulation.

If risk assessment and risk adjustment are done properly, a separate re-insurance pool probably would not be required. While re-insurance does protect carriers from extremely high-cost cases, it can reduce the incentive for carriers to effectively and efficiently manage care. This would not be in the best interests of Colorado.

**Assure Effective, Efficient, Safe Care**

Health care is not as efficient, safe or effective as it should be, nor are consumers getting optimal value from their purchase. While universal coverage is critical to achieving cost-containment and developing a safer, more efficient health system, this cannot be sustained unless attention is paid to improving the quality and efficiency of health care delivery. Without such improvement, expanded access will be insufficient to contain costs. Continued cost increases would threaten any gains in coverage that are achieved.

Universal coverage is itself a cost-containment strategy by virtue of reducing cost shifts for uncompensated care and by providing preventive services and efficiently provided acute and chronic care. But it is not a sufficient strategy alone.

Delivery-system integration will provide the greatest efficiency gains. We need to align the incentives and workflow of the various components of health care delivery—primary care and specialty care, hospitals, laboratories, pharmaceuticals, etc.,—into a single system dedicated to a common goal of improving health. The delivery system's outcomes must be aligned in a coordinated fashion that results in cost savings that can assist in increasing the numbers of insured people under this proposal. Achieving this essential goal will require carriers to work with physicians to develop systems and incentives for practicing effective care.

Essential elements of this redesigned care-delivery system should include the following:

Patient-centered care: The concept of a medical home, or primary physician who coordinates the care for patients, is essential. Both providers and patients must be educated regarding the proper use of medical services to achieve the mutual benefits of cost containment and improved outcomes.

Patient safety: Following the principles of patient safety, care teams should be developed that focus on those office- and facility-based systems in which patients receive care. Data for public reporting should be developed in collaboration with a number of groups, appropriate information technology should be widely used and a variety of task forces and interventions supported. The most recent action is the creation of the Nurse Workforce and Patient Care Task Force which will make recommendations to the Governor and General Assembly by the end of the year.

Adherence to and development of evidence-based guidelines: Expanding the work and influence of organizations such as the Colorado Clinical Guidelines Collaborative would enhance the delivery of care using best practices. Carriers should work with medical organizations to develop incentives for using evidence-based clinical guidelines and should consider addressing use of technologies and medical practices for which there is not evidence of effectiveness. Guidelines for preventive services, including immunizations and periodic screening, should be part of an essential benefits package and providers should proactively address these basic health care needs following HEDIS® and US Preventive Services Task Force guidelines, for example.

Health Information Technology: One critical component of both patient-centered care and patient safety is the use of an automated interoperable medical record, that includes office notes, and pharmacy, laboratory, and radiology records at a minimum. As part of adherence to clinical guidelines, one incentive that should be considered is the provision of a statewide health information system in all participating offices. The state should

consider using the Colorado Regional Health Information Organization (CORHIO) to set minimum standards for use and maintenance of these systems. This work is an investment in both quality and affordability, and will require financial support for its success.

Disease state management: There is ample clinical evidence that coordinating the care of patients with a number of chronic diseases is cost-effective and enhances the likelihood of improved outcomes. Carriers should assure that disease state management is used when possible. One example of this would be the use of asthma care management for kids, cardiovascular disease management for adults, and diabetes care management for both.

Prevention: Prevention is the ultimate cost-containing strategy. Benefit plans must include effective prevention measures, Health Risk Appraisals and the development of personal care plans that address prevention, risk and illness management. Community-wide collaborations that focus on healthy lifestyles such as *Live Well* will also be helpful.

System timeliness and efficiency: In order to achieve cost savings and reduce misuse of medical services, including misuse of emergency services, service metrics should include access for appointments, ease of reaching the medical office, and some measures of the effectiveness of clinician-patient communication. Data about the access to specialty and other services should be tracked and incentives for improving access and timeliness should be developed by carriers and providers.

The proposal to the Blue Ribbon Commission for Health Care Reform from the Colorado Foundation for Medical Care (CFMC) and the Colorado Clinical Guidelines Collaborative (CCGC) contains very thoughtful ideas and should be closely examined.

## Cost Containment

There are three primary mechanisms in this proposal that support cost containment. First, streamlining CHP+ and Medicaid, adding cost-sharing and increasing the use of HMOs will produce savings. Second, improvements in the health care delivery system will not only result in improved quality but also support cost containment. Third, the structured approach to personal responsibility, carrier transparency and accountability and competition based on price, quality and service will improve the value of the health care system and manage costs.

Price competition by carriers is on monthly premiums, not on prices for individual services. Premiums, of course, approximate the annual per-person cost for the covered set of services. It gives the individual an incentive to choose the carrier that minimizes total cost while providing demonstrated quality of care. Having access to premiums (and quality results) for all benefit plans offered by all carriers at the time an individual makes a choice, gives the individual the opportunity to make a wise choice. Making choices based on premiums is much more powerful than having comparative prices for individual services. Sick patients and their families, especially those without medical training, are in a very poor position to make wise decisions about long lists of individual services they might or might not need. They need to be able to rely on their doctors to advise them about what services they need and on their carriers to get good prices and on both to effectively and efficiently coordinate care. When individuals choose the plans offering greater value, there is a huge incentive for other plans to improve the value they offer, including improving outcomes, access and satisfaction and reducing premiums (price). Publicly reporting quality, access, satisfaction and price is, by itself, a motivator for improvement.

The benefits to be offered are another cost-containment tool. Each plan needs to have individual, provider and carrier incentives to do the right thing efficiently and to reduce the likelihood of providing inefficient care. Examples include incentives to get proven prevention services, participate in disease management programs, comply with physician instructions, and disincentives to use emergency rooms as primary care visits, or select a more expensive option when its effectiveness is the same as a lower cost

option. Benefits might be tailored to recommendations for specific diseases. For example, there is some evidence that reducing the price for certain diabetic supplies and drugs not only improves outcomes but reduces cost.

**Universal coverage for those 0 – 18 :** During this phase all persons from birth through age 18 will be required to have health coverage. In addition to providing health coverage for this population, during this phase Colorado will assess the individual mandate and guaranteed issues systems and make necessary adjustments. In essence, this population will serve as a pilot.

We propose beginning with children for a number of reasons. The ages zero through 18 set the stage for life-long health. Many preventive services are provided during these years. The development of good health habits is crucial during these years as well and will have lasting impact in maintaining good health. These are the ages that Colorado should be investing in Coloradans' health. Healthy individuals, of course, require fewer services and have lower average costs. In addition, a substantial percentage of this population is covered through CHP+, reducing the stress on newly built systems and affording the opportunity to fix the systems prior to more widespread use. In addition, this expansion will be less expensive than other population groups.

For this group only, the CHP+ program should be an additional coverage option.

**Universal coverage for additional age groups**

As rapidly as funds are available, and when there is confidence in the individual mandate and guaranteed issue systems, additional populations will be covered. For example, the state could choose to extend sequentially universal coverage to:

- adults 19 – 29;
- adults 30 – 39;
- adults 40 – 49;
- adults 50 – 59;
- adults 60 – 64;
- adults 65 and older not qualifying for Medicare.

**Migration to more comprehensive benefits**

Once the entire population is covered by at least basic benefits and the individual mandate, guaranteed issue and risk adjustment systems are working smoothly, the guaranteed issue plans should be migrated to more comprehensive coverage.

**Funding:**

Savings will be realized through streamlining public programs, instituting cost-sharing and increasing the use of managed care. These savings can then be applied to coverage expansion. Additional Medicaid reform should produce additional savings. Once Colorado approaches universal coverage, public funds currently used to support CoverColorado and the Colorado Indigent Care Program can be applied to premium assistance under this program.

As more persons are covered in Colorado, there should be less uncompensated care and bad debt, and therefore less cost shifting. California estimated cost shifting to increase prices 10%. Maine hoped to fund their program through "savings offset payment," generated through recovery of bad debt and charity. However, there has been a major disagreement about how much these savings are and whether this is a good source of funding. We recommend not using these potential savings as a funding stream, and, instead, anticipate an overall reduction in health care costs over time that will benefit everyone.

However, additional funds will be required to expand coverage and provide premium assistance. There are many funding sources that, at least in combination, would generate sufficient revenue to fund universal coverage. However, some sources may have less desirable effects long term, such as creating unnecessary difficulties for starting, sustaining or growing business. Other sources may not be politically palatable. In all, funding probably is the most difficult part of being able to reach universal coverage. Funding sources should be broad-based, not disproportionately impact any one sector, not increase the cost of health care, include personal contribution to the cost of coverage and the use of health services, and include both private and public sources.

(2) *Who will benefit from this proposal? Who will be negatively affected by this proposal?* The beneficiaries will be the thousands of currently uninsured or underinsured Coloradans, Colorado health care providers who currently experience significant issues with bad debt, carriers and insured individuals and employers who currently experience significant cost-shifting because of the bad-debt load, and employers and schools who have employees and students either absent or not fully functional because of unaddressed health issues. Negatively affected will be persons who do not currently pay for the health care they receive and who will be required to pay for all or part of their health care premiums. Depending on the funding sources selected, negative impacts may be felt by employers who might have to help pay for this system, persons who might have to pay more for tobacco or alcohol products, persons who might have to pay more in sales taxes, individual and corporate taxpayers who might have to pay more in income tax.

(3) *How will your proposal impact distinct populations (e.g., low-income, rural, immigrant, ethnic minority, disabled)?* As populations are phased in, all persons who file Colorado income taxes and live in the state will be covered without respect to race, ethnicity, place of residence, or health status. Low-income persons will be covered by public programs or receive premium assistance. Individuals will be able to choose from a variety of benefit plans and carriers to best meet their needs.

(4) *Please provide any evidence regarding the success or failure of your approach. Please attach.* It is difficult to provide evidence regarding the success or failure of our approach because no state has yet to implement all of our proposed phases as a single program. Our proposal is meant to be taken as a comprehensive package, and we do not recommend implementation of some parts without others. In particular, implementation of an individual mandate without choice of plans and carriers is not meaningful. Implementation of guaranteed issue without individual mandate is a recipe for disaster. However, following is some evidence regarding individual components.

The cost savings of streamlining CHP+ was extensively studied by the Colorado Family Care effort. See: www.chcpf.state.co.us/HCPF/titlexxi/StatePlan/Colorado%20Family%20Care%20HIFA%20Waiver%20Report%20070105.pdf.

A large body of research has focused on the optimal size of subsidies needed to induce people to buy coverage (in a voluntary market). It is clear that people's decisions to buy nongroup coverage is highly sensitive to price, and that the subsidy levels might have to be very high. See for example: S. Marquis and S. Long, "Worker Demand for Health Insurance in the Nongroup Market," *Journal of Health Economics* 14, no.1 (1995) pp. 47-63.; S. Marquis et al, "Subsidies and the Demand for Individual Health Insurance in California," *Health Services Research*, 39 no.5 (October 2004), pp. 1547-70; L. Ku and T.A. Coughlin, "Sliding Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, 36, no.4, Winter 1999/2000, pp. 471-480; K.E. Thorpe, "Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured," in Severing the Link Between Health Insurance and Employment, D. Salisbury, Editor, Employee Benefit Research Institute, Washington, DC, 1999. www.ebri.org/pdf/publications/books/severing_the_link.pdf

No state has yet to implement an individual health insurance mandate, so it is not possible to refer to others' experience. Massachusetts will be the test case for this type of reform. It is common to refer to the experience of the automobile insurance market, where there is a mandate. In Colorado, despite the mandate, anywhere from 9 to 22 percent of automobiles are uninsured. (*Colorado Uninsured Motorist Report to the Division of Insurance in Response to HB 97-1209*, 2002, Colorado Division of Insurance, Denver, CO, http://www.dora.state.co.us/insurance/pb/um02.pdf) However, in the case of auto insurance there are few enforcement mechanisms, nor are there subsidies for lower-income people. Without the administrative infrastructure we recommend, a health insurance mandate is likely to fall well short of universal coverage.

It is widely agreed that states' experience with guaranteed issue of nongroup coverage, particularly when coupled with rating reform (rate bands or community rating), has been negative. When carriers are required to issue coverage to all-comers and are

constrained in the rates they can charge, premiums in the nongroup market quickly become too expensive for the healthy low-utilizers, and they drop out of the market. Over time, the nongroup market becomes a high-risk pool. For an excellent of summary of recent studies on the impact of small-group and nongroup insurance reforms in the states, see the Wake Forest University Health Insurance Market Reform Study, http://www.phs.wfubmc.edu/web/public/pub_insurance/pub_insur_summary.cfm. Also see: M.A. Hall, "An Evaluation of New York's Reform Law," *Journal of Health Politics, Policy and Law*, 25 no.1 (2000), pp. 71-99; M.A. Hall, "An Evaluation of Vermont's Reform Law," *Journal of Health Politics, Policy and Law*, 25 no.1 (2000), pp.101-131; K. Swartz and D. Garnick, "Lessons from New Jersey," *Journal of Health Politics, Policy and Law*, 25 no.1 (2000), pp. 45-70; C.F. Meier, Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Insurance Market in Eight States, Council for Affordable Health Insurance (Alexandria, VA) and The Heartland Institute (Chicago, IL), 2005.

Guaranteed issue only can work when both the healthy and the sick participate in the market. Without mechanisms to keep the healthy people in the market, the risk pool becomes unbalanced and unsustainable. This is why we believe that the guaranteed issue portion of our proposal cannot be implemented without the individual mandate and subsidies for low-income people. To do so would be to invite repetition of the disasters that took place in other states.

(5) *How will the program(s) included in the proposal be governed and administered?* The CHP+ and Medicaid programs will be administered by the Colorado Department of Health Care Policy and Financing. We recommend the Colorado Department of Revenue manage the individual mandate system. The Colorado Division of Insurance should manage the guaranteed issue system. A state agency should be selected to design and administer the risk adjustment system. A governor/legislature appointed board, staffed by the Department of Health Care Policy and Financing will determine required benefit packages. The state should consider what elements to contract out, such as the information technology for the individual mandate system and the risk adjustment system.

(6) *To the best of your knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g., federal Medicaid waiver, worker's compensation, auto insurance, ERISA)? If known, what changes will be necessary?* A federal waiver might be needed to streamline Medicaid/CHP+. A Medicaid State Plan Amendment will need to be approved for cost-sharing. Eligibility for CHP+ should be increased as much as possible to be consistent with federal fund availability. This might require action by the state. All willing HMOs should be included in the CHP+, which would require a state law change. The Colorado Insurance Code would need to be modified to establish criteria for guaranteed issue. The Colorado Tax Code would need to be modified to establish requirements to file proof of coverage. The Colorado Corporate Code might need modifications for employer responsibility.

(7) *How will your program be implemented? How will your proposal transition from the current system to the proposal program? Over what time period?* The first step of streamlining and expanding CHP+ and Medicaid can begin immediately. Changes requiring a federal waiver or Medicaid state plan amendments can be made as soon as necessary approvals are obtained from the state and federal governments. Aggressive outreach and enrollment for CHP+ then may begin. Building the necessary systems to assure continuous coverage of all eligible persons (individual mandate), assuring choice of coverage (guaranteed issue), and improving Colorado's health care systems can begin immediately upon legislative approval. Instituting universal coverage for children birth through 18 can begin as soon as the systems of individual mandate and guaranteed issue are finalized. Progressively instituting universal coverage through individual mandate can begin as funds become available.

c) Access

(1) *Does this proposal expand access? If so, please explain.* Yes, this proposal expands access through covering more children under CHP+ and by

mandating individuals obtain coverage through public programs, employers or direct purchase.

(2) *How will the program affect safety net providers?* Safety-net providers will continue to be an important part of the delivery system. As more and more people are covered, their revenue will increase from treating persons formerly uninsured.

(3) *Does your proposal "expand health care coverage?" How?* Health care coverage will be expanded in steps: first, more children will be covered by CHP+ (and eligibility will be expanded to higher income levels if federal funding increases). Second, other children birth through 18 will be required to have health coverage. Third, other populations will be required to have health coverage as funds become available. At the final phase, all residents of Colorado who file state income tax will be covered by their choice of carrier. Finally, after all Coloradans have at least basic coverage, the state will migrate to more comprehensive benefit plans.

(4) *How will outreach and enrollment be conducted?* For the voluntary component of this proposal (streamlining and expanding public programs), multiple systems will be required. CHP+ has developed a comprehensive outreach system. The state should invest in an easy electronic system deployed at multiple points to determine eligibility and apply for public programs. A simple enrollment application for CHP+/Medicaid will be needed. Employers and other groups will enroll employees as they do currently. For the individual mandate portion of this proposal, the state income tax system will be the primary vehicle. Carriers will be required to cover all eligible persons (guaranteed issue).

(5) *If applicable, how does your proposal define "resident?"* We propose that premium assistance be available to persons living in Colorado who are

covered by the individual mandate provision, meet the income limitations and are required to file a Colorado income tax return. For the relatively few people whose taxable income did meet the threshold for required filing (nationally about 5% of the population; nearly half of whom are seniors), there would be a mechanism whereby they could apply for premium assistance. The individual mandate and guaranteed issue provisions will apply to all residents of Colorado who file state income tax. Eligibility for public programs will remain as specified by federal law.

It is important that Colorado avoid incentives for people to move to Colorado merely to enroll in a health plan. However, duration of residency requirements for public health care programs has been held unconstitutional by the U.S. Supreme Court. Given that persons covered by the individual mandate/guaranteed issue provisions would be required to pay part of the premium, such an incentive may not exist. The state should monitor enrollment of new residents and develop alternatives to manage the issue, should it develop.

d) *Affordability*

(1) *If applicable, what will enrollee and/or employer premium-sharing requirements be?* Cost-sharing now is allowed for populations covered by Medicaid and CHP+ and should be applied. For products to be offered on a guaranteed issue basis to those subject to individual mandate, the following should be evaluated:

| **Percent of Federal Poverty Level** | **Subsidy per month based on the median cost basic plan or comprehensive plan with deductible available in the person's area** |
|---|---|
| <150% | 95% |
| 150%-200% | 85% |
| 201%-250% | 65% |
| 251%-275% | 50% |
| 276%-300% | 25% |
| Over 300% | No subsidy |

(2) *How will co-payments and other cost-sharing be structured?* This is an area that must be modeled. There are tradeoffs between cost-sharing, prices (premiums), premium assistance required, availability of federal funds, availability of state public and private funds and the number of people that can be covered.

e) *Portability*

(1) *Please describe any provisions for assuring that individuals maintain access to coverage even as life circumstances (e.g., employment, public program eligibility) and health status change.* As part of the individual mandate system, enrollment rules must be specified. Our proposal is that after the initial enrollment period when all eligible persons enroll in their plan of choice, individuals will be allowed to change benefit plans and/or carriers once a year in the month of their birthday. This restriction is necessary to avoid adverse selection against the more comprehensive plans. However, there will be a special enrollment period for persons experiencing a significant life event such as marriage or divorce, loss of employment, or death of a spouse. Individuals also will be able to request additional assistance if their income changes or if they experience hardship.

f) *Benefits*

(1) *Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations*. The public program benefits proposed are currently in use by CHP+, although we propose adding cost-sharing to that plan. We propose an annual review of benefits to assure benefits support the simultaneous goals of improving health, providing quality of care and service and managing costs. The benefits proposed for guaranteed issue in the direct market are designed to meet most of the outpatient needs, supporting the goal of improving health by providing preventive services and early intervention of illness and health risks. This plan is the most affordable, but would still result in some unfunded care. In addition, we propose a plan or plans that cover basic outpatient needs and comprehensive services with a deductible. Those plans will cost more, but also cover more health services. Those plans also will result in less unfunded care and therefore less cost-shifting. Once all eligible Coloradans are covered by at least the basic benefit, and the health care system is providing better value, the state can determine if it is possible to enhance the basic benefit.

(2) *Please identify an existing Colorado benefit package that is similar to the one(s) you are proposing (e.g., Small Group standard Plan, Medicaid, etc.) and describe any differences between the existing benefit package and your benefit package.* Individuals must have a choice of carrier and benefit package that best meets their needs, and promotes the use of effective, needed services and avoids the use of ineffective services or the overuse of services. The beginning package is the existing CHP+ plan (with additional benefits as required for Medicaid children moving to CHP+ should that option be selected). When the Benefit Design Advisory Committee completes its work, that plan should be considered. In addition, periodic Health Risk Appraisals and an accompanying personal health plan developed in partnership with their physician will be covered. Benefits should be reviewed annually, including

input from consumers, providers and carriers, and benefits adjusted as needed. Early review to identify and remove barriers to effective preventive services is needed. The basic benefit plan currently is not offered, to our knowledge. The comprehensive plans with deductibles are offered in various permutations by various Colorado carriers.

g) *Quality*

(1) *How will quality be defined, measured, and improved?* All carriers will be required to report quality, access and satisfaction measures, such as HEDIS® and CAHPS®, as determined by the state. The data from these systems would be published by the state. The state also could consider requiring carrier accreditation.

(2) *How, if at all, will quality of care be improved (e.g., using methods such as applying evidence to medicine, using information technology, improving provider training, aligning provider payment with outcomes, and improving cultural competency including ethnicity, sexual orientation, gender identity, education, and rural areas, etc.?)* Carriers and the statewide managed indemnity plan will be required to measure and report on standardized, audited elements of quality, access and satisfaction. Public disclosure of results is a powerful motivator for improvement. In addition, the state should develop incentives for carriers to reach certain quality/access/satisfaction targets. In turn, carriers should develop appropriate systems and incentives to assure the provision of effective, efficient care.

h) *Efficiency*

(1) *Does your proposal decrease or contain health care costs? How?* Universal coverage is required in order to make the system more affordable. Without universal coverage, uninsured and underinsured persons still receive many services—but less efficiently than insured persons do. By removing barriers to

receiving preventive and routine care, by promoting the use of effective preventive services and by having individuals complete a Health Risk Assessment and accompanying personal health plan, Coloradans' health will improve, reducing overall health care costs. However, initially there will be an increased use of outpatient services, especially by those previously uninsured, as previously unmet health care needs are addressed.

(2) *To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services? Please explain.* Public reporting of results by carrier is a powerful incentive for improvement. In addition, carriers will be encouraged to develop incentives for individuals to improve their health and use health services appropriately. Carriers also will be encouraged to develop systems and incentives that support the provision of safe, timely, effective, efficient, patient-centered care. Finally, the state could develop incentives for carriers to reach certain quality/access/satisfaction targets through increased payment and/or increased enrollment.

(3) *Does this proposal address transparency of costs and quality? If so, please explain.* Each carrier would be required to report annually on state-determined, specified and audited measures of quality, access and satisfaction. The state should consider requiring reporting using existing systems such as HEDIS® and CAHPS®.

(4) *How would your proposal impact administrative costs?* A concerted effort to streamline public programs, develop simplified application and eligibility systems and the like will reduce administrative costs. Once all populations are covered, other costs are eliminated, such as carrier medical underwriting.

i) *Consumer choice and empowerment*

(1) *Does your proposal address consumer choice? If so, how?* Persons covered by the individual mandate, and not eligible for public or group coverage, will have a choice of several benefit plans and all participating carriers in their geographic area. In addition, they will have a choice of primary care physicians within their selected plan. By improving physician reimbursement, public program participants will have more physician choice within the statewide managed indemnity plan.

(2) *How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions?* Each benefit plan will include the completion of a Health Risk Appraisal and encourage the completion of a personal health plan with their PCP. This provides personalized information about the person's health and potential impact on longevity and guidance on what the person can do to improve his/her own health. For persons with a chronic illness, participation in a disease management program also will provide personalized information and guidance to better manage their illness and prevent additional issues.

j) *Wellness and prevention*

(1) *How does your proposal address wellness and prevention?* Carriers would be required to report on the percentage of their members who have completed certain preventive services, such as immunizations and screening. This provides an incentive for carriers to develop systems to increase those percentages. The benefit package should include effective preventive services at low or no copayment. Including a Health Risk Appraisal and personalized health plan will provide each individual with key information about his/her own health and tools to reduce their risk factors and improve their health.

k) *Sustainability*

(1) *How is your proposal sustainable over the long-term?* Once fully implemented, Coloradans' overall health should improve, cost shifting should be eliminated, and the health care system should be characterized by safe, timely, effective, efficient and patient-centered care. That being said, however, additional sources of revenue will be needed year after year. In the broadest sense, unless we can increase employment and improve family incomes, the system will require constant infusion of revenue from one or more sources.

(2) *(Optional) How much do you estimate this proposal will cost? How much do you estimate this proposal will save? Please explain.*

(3) *Who will pay for any new costs under your proposal?* Identifying new sources of funding will be the most difficult part of implementing universal (or even expanded) coverage. We recommend that funding sources be broad-based, not disproportionately impact any one sector, not increase the cost of health care, include personal contribution to the cost of coverage and use of health services, and include both private and public sources. The ultimate decision is largely a political one: what sources will be acceptable to the citizens?

(4) *How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increase or decrease costs? Please explain.* If the funding sources selected are broad-based, nearly everyone pays more. Individuals and employees who did not have health coverage, but are now required to, will pay more. Employers will benefit from a reduction in cost-shifting, perhaps reducing premiums. Consideration will have to be given to how employers who have not provided health coverage for their employees will participate in the costs of the system.

Government will need to build and maintain the systems to have universal coverage work, but will benefit from administrative streamlining as well.

(5) *Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain.* This is an area that must be modeled along with the next question about cost-sharing. There are tradeoffs between cost-sharing, prices (premiums), premium assistance required, availability of federal funds, availability of state public and private funds and the number of people that can be covered.

(6) *(Optional) How will your proposal impact cost-sharing. Please explain.*

(7) *Are new public funds required for your proposal?* Yes. It is inescapable that total costs will increase. However, universal coverage is also a necessary ingredient to improving value and managing cost.

(8) *(Optional) If your proposal requires new public funds, what will be the source of these new funds?*

*3. A single page describing how your proposal is either comprehensive or would fit into a comprehensive proposal.*

This proposal is comprehensive not only because it expands coverage to all Coloradans but also because it addresses improvements in the efficiency, effectiveness, and safety of our health care system.

Once fully implemented, all residents of Colorado who file state income taxes will be covered. The proposal, however, builds step by step to universal coverage. The initial step is to streamline and expand CHP+ and reform Medicaid. This will provide coverage to the most needy and use federal matching funds to help fund the system. It also will extend coverage to more children.

The next step (which can begin immediately) is to build systems that ensure continuous coverage of eligible persons and assure that those persons have choice of carriers and benefit plans. We propose phasing universal coverage by age group, beginning with children 18 and under and adding successive age groups as funds become available. We also propose that every Coloradan have his or her own personal physician so that care is proactive and coordinated.

The proposal envisions comprehensive benefits for all Coloradans. But initially, coverage subsidized by the state will be less comprehensive in order to be affordable.

We strongly believe that a comprehensive approach also should include improvements in the way we deliver health care. Coloradans will get more for their money when the system reduces duplication, reduces errors, takes better care of people with chronic conditions, encourages healthy lifestyles, and follows the latest evidence on treatment. The state must foster use of electronic medical records so that consumers' health care can be better coordinated, their information is portable from one provider to another, and risk of error is reduced.